

A Closer Look at Visitation Hour Policies in Intensive Care Units

Micheal Banh

The University of Kansas School of Nursing

About the author:

Micheal Banh is from Wichita, Kansas. While attending the School of Nursing he received a clinical excellence award for his work in the pediatrics clinical and honorable mentions for his work in his obstetrics clinical. He is a graduate of the School of Nursing Honors Program. He plans on starting his nursing career in Denver Colorado. His future plans include returning to school for a Doctorate of Nursing Practice with long range plans to work in both an urban and a rural environment through the use of telenursing.

Introduction

Visitation policies on intensive care units establish the groundwork for balancing the needs of a critical patient and family members as well as the unit staff. The unit's specific policy on visitation hours sets the tone for interactions between all parties and can have a significant effect on patient outcomes, family satisfaction, and stress for nursing staff. A growing body of evidence points toward better outcomes for patients and families on units with more open visitation policies yet there are a number of hospitals, patient care units, and individual nurses that still support restricted visitation hours. While many intensive care units have legal backing to establish visitation policies, it becomes an ethical battle when balancing the needs and satisfaction of nursing staff, patients, and family. It is important to understand the rationale behind arguments on both sides to better address the issue, especially to understand why some units do not follow evidence-based practice guidelines that support open visitation policies. The purpose of this paper is to explore the relevant research regarding visitation policy on intensive care units to better understand the status quo and to clarify major rationales. This will be accomplished by a review of literature that will discuss the topic and a conclusion that provides nursing implications for practice in light of the research presented.

Review of Literature

Intensive care units were initially guided by the idea that outside visitors would detract from the ability of critically ill patients to heal so their involvement was greatly limited to brief visits. As more research was released regarding visitation hours, many institutions began to shift their paradigms to reflect current trends. As there is "an increased emphasis on customer needs, hospitals are searching for better ways to enhance satisfaction" (Whitton & Pittiglio, 2011, p. 365), which has placed a greater emphasis on visitation hours and other ways that the institution

interfaces with patients and families as consumers. Nurses are in a unique position to facilitate these interactions as they serve not only as patient advocates but also as “primary gatekeepers” (Farrell, Joseph, & Schwartz-Barcott, 2005, p. 19) to intensive care units and generally have the ability to direct traffic related to their patient care. Farrell et al. (2005) noted inconsistencies in the enforcement of hospital policy where 70% of five hospitals in a Midwestern city were shown to have “restrictive” policies in a study while 78% of the nurses had “nonrestrictive” policies of their own (p. 20). Although individual institutions may effectively curb the varying enforcement of their own visitation policies, it is assumed that this phenomenon is not unique to the Midwest. This kind of “inconsistent enforcement” can “[confuse] visitors and [cause] strife among nursing staff” (Lee et al., 2007, p. 500), which is not only in conflict with institutional policy but distressing to all parties, involved. This frustration could contribute to resistance to change. Livesay, Gilliam, Mokracek, Sebastian, & Hickey (2005), noted in their study of a neuroscience intensive care unit that inconsistent policy implementation continued to be an issue, “a clear and uniform policy and implementation procedure could decrease the frustration and dissatisfaction of the nurse at the bedside as well as patients and their visitors” and that “multilevel education” is suggested to ensure consistency (p. 188). Nurses are given great power regarding visitation and it is clear that this power can become a source of great consternation to patient, families, and nursing staff when individual adherence to unit policy is not consistent across the unit. Given the evidence that individuals do not always follow restrictive policies, it is clear there is significant resistance to restrictive policies and the rationale behind the decisions of such a large number of nurses should be analyzed.

Open visitation policies are being slowly adopted across intensive care units. Whitton & Pittiglio (2011), suggest that “an increased understanding of family members’ needs and wants in

regards to the care of their loved one while in the ICU may lead to improved satisfactory outcomes” such as a decrease in anxiety (p. 365). Lee et al. (2007) notes that the family members can become a part of the care team itself (p. 499) and Daniels & Ventura (1996) suggested that “the nurse can teach the family almost continually” to eventually empower the family members to provide certain aspects of patient care themselves while the authors also noted some anecdotal examples of family members benefiting patient outcomes, such as a family calming down a confused patient who “otherwise would have necessitated restraints”. Having family members around for these occasions allows for more positive consumer experiences in intensive care units while their presence has tangible benefits to the patient as well.

Opponents to open visitation policies suggest that visitors can upset vulnerable patients and expose them to pathogens. However, research indicates just the opposite. Lee et al. (2007) notes “published studies have failed to demonstrate any physiologic change during or after family visitation that may hinder patient recovery” (p. 500). Livesay et al. (2005) came to a similar conclusion regarding neuroscience intensive care unit patients in that there is “no conclusive evidence to support a deleterious physiological effect of family visitation on neurological patients” (p. 183) nor was there “evidence to support detrimental effects of liberal visitation on the patient in the 24-bed ICU” (p. 183). In fact, Livesay et al. (2005) noted studies which indicated that family visits had decreased patient intracranial pressure and had improved mental status scores (p. 183). Fumagalli et al. (2006) conducted a pilot study comparing unrestrictive visiting policies with restrictive visiting policies and concluded that while there is an increase in introduced infective agents, there was no increase in risk of sepsis as well as the associated reduction in anxiety is “associated with a somewhat more favorable hormonal profile” that could “be beneficial in terms of reduced cardiovascular complications” (p. 950). There is

clearly a large amount of evidence that suggests family visitation is at the very least benign and potentially beneficial under the right circumstances.

It is germane to discuss why some nurses oppose open visitation hours in spite of the breadth of research suggesting significant benefits. Lee et al. (2007) suggests that some nurses feel that the benefits are gained only “at the expense of nursing satisfaction” and that “staff safety is a real concern” along with the transference of anxiety and stress from family to nurse (p. 497). Lee et al. (2007) determined that the three main areas of nursing concern through their study’s questionnaire were space, involving confidentiality and overnight guests; communication and conflict, involving family as a physical barrier and issues with inconsistencies with restrictive visitation hour enforcement; and burden, involving the need to attend to the family’s needs in addition to the patient’s needs (p. 500). To establish a medium ground, Lee et al. (2007) utilized focus groups of intensive care unit nursing staff to assist with establishing interventions which included establishing a visitor liaison to address family needs as well as creating educational pamphlets that brief visitors on policies and what to expect from the unit, among other suggestions (p. 500). Farrell et al. (2005) suggests, “perhaps another role should emerge... that of family caregiver. A knowledgeable person to focus on the family’s needs leaving the nurse to focus on managing the unstable patient” (p. 27) which is similar to the visitor liaison suggested by Lee et al. (2007, p. 500). Daniels & Ventura (1996) suggest that large families establish their own spokesperson to get information from the nurse as well as a way to streamline information flow and care to the patient. In any case, Whitton & Pittiglio (2011) point out, “although ICU nurses agree that open family visitation may interfere with some aspects of patient care, the benefits to the patient overwhelmingly outweigh the risks” (p. 363).

Conclusion

The review of literature establishes a few trends regarding visitation hour policies in intensive care units. Various studies noted the nurse's power to regulate traffic is a strong tool that should be used consistently to avoid problems with visitors and units should work to establish clear guidelines. Evidence indicates no harm in having open visitation policies for the patient and in fact points to some potential benefits. Trends show that resistance to adopting open visitation policies is based on nurse concerns with additional stress from visitor involvement and potential miscommunication. The actual benefits from evidence-based practice and quality research should be presented to units and individuals who do not agree with open visitation policies and intensive care units should work to establish some ways to reduce nurse stress while adopting an open visitation policy. A number of studies suggested establishing a liaison and educational materials for families that would directly address many nursing concerns. As a patient advocate, nurses should consider the benefits to their patient gained from visitor interaction and spark change on their own units rather than resist change that would benefit patients simply because it opens the doors to having to interact with patient families. It is important to care for the patient and his or her family as a unit to better address the needs to all involved for better outcomes. While legal, to exclude visitors through a restricted visitation policy on intensive care units in the face of the mounting evidence presented above seems to be an act of questionable ethics as beneficence is not being upheld.

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